TRAUMATIC INJURY PROTECTION (TSGLI) UNDER THE SERVICE MEMBERS' GROUP LIFE INSURANCE PROGRAM CERTIFICATION FORM AND INSTRUCTIONS



Administered by the
Office of Servicemembers' Group Life Insurance
290 West Mount Pleasant Avenue
Livingston, NJ 07039-2747
Toll Free Telephone: 1-800-419-1473

Toll Free FAX: (877) 832-4943

TSGLI Certification Package, Edition September, 2005



HOW TO CERTIFY PAYMENT OF TRAUMATIC INJURY PROTECTION (TSGLI)

TSGLI

Effective December 1, 2005, service members who are insured under SGLI and suffer a loss from a traumatic injury are eligible to receive monetary compensation for a total amount not less than \$25,000 and not greater than \$100,000.

Form GL.2005.261

To submit a certification, the service member, the attending physician, and the branch of service must each complete this form in accordance with the instructions on the next page.

Method of Payment

Electronic Funds Transfer (EFT)

The benefit will be electronically credited to the bank account specified. This account should be the account of record for payroll purposes. If EFT is not chosen, and there is no guardian or Attorney in Fact, the payment will be made through Prudential's Alliance Account.

Prudential's Alliance Account®*

The benefit will be deposited into Prudential's Alliance Account in the service member's name. The Alliance Account offers the following features:

A personal interest bearing account, which gives the service member ready access to the money, whenever it is needed. To use the account, the service member can simply write a check for the withdrawal amount. The minimum withdrawal is \$250. The service member may write out one check for the entire amount and close the account, or write checks as the money is needed. Interest will continue to be earned on any balance maintained in the account.

What Else You Should Know

TSGLI will be paid directly to the member, **EXCEPT when**:

The member is incompetent –

• In such event, payment will be made by check or EFT to the member's Guardian or Attorney in Fact under a Durable Power of Attorney. Please include copies of letters of guardianship, conservatorship, or Power of Attorney, etc. with this form. In this case, Alliance Account payment is not an option.

The member dies after qualifying for payment but before payment can be made –

• In such event, payment will be made to the member's listed SGLI Beneficiary(ies).

What should be done with the completed certification form?

Once the form is completed, please send it to OSGLI, by toll free fax to 1-877-832-4943, or by mail to: **OSGLI-TSGLI Claim Processing**, 290 West Mt. Pleasant Avenue, Livingston, NJ 07039-2747

Any questions regarding the completion of this form, please call OSGLI toll free at 1-800-419-1473 Or e-mail us at osgli.claims@prudential.com.

^{*} Prudential's Alliance Account is a registered trademark of The Prudential Insurance Company of America. BISYS Information Solutions, L.P. is the Administrator of the Prudential Alliance Account Settlement Option, a contractual obligation of The Prudential Insurance Company of America, located at 751 Broad Street, Newark, NJ 07102-3777. Check clearing is provided by Bank One and processing support is provided by Integrated Payment Systems, Inc. Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC). BISYS Information Solutions, L.P., Bank One, and Integrated Payment Systems, Inc. are not Prudential Financial companies.



INSTRUCTIONS

PART A - To be completed by Service Member

Section 1 - Service Member Information

Section 1 of the form requests identifying information for the service member on whose behalf the benefit will be paid.

Section 2 – Guardian or Attorney in Fact Information

If anyone other than the service member will receive payment, please include copies of the letters of guardianship, conservatorship, or Power of Attorney, etc. with this form. Failure to include this documentation will delay payment of the benefit. If there is a Guardian or Attorney in Fact, Alliance Account payment is not an option.

Section 3 – Payment Information

Section 3 requests selection of a payment method for the TSGLI benefit. Only one method of payment should be selected. If payment is being made to the service member, only EFT or Alliance Account may be selected. If payment is being made to a guardian or Attorney in Fact, only EFT or check may be selected.

If the payment is to be deposited electronically into the service member's account, please check the Electronic Funds Transfer (EFT) box and complete the banking information. All information is required.

If the payment is to be deposited into an Alliance Account and a checkbook mailed to the service member, please check the Prudential's Alliance Account® box and complete the address to which the checkbook should be sent. Alliance Account checkbooks are sent by overnight delivery and, therefore require a street address. They cannot be delivered to Post Office boxes.

If neither method is indicated on the form, and there is no guardian or Attorney in Fact, the benefit will be paid through the Alliance Account. The checkbook will be mailed to the address of record listed in Section 1.

Section 4 - Signature

The service member, guardian, or Attorney in Fact must sign this section.

Section 5 – Authorization to Release Information

The Authorization to Release Information must be completed and signed by the service member, quardian, or Attorney in Fact.

PART B – Physician's Statement

The Physician's Statement asks the attending physician (military or civilian) to give details of the injuries that qualify the service member for the TSGLI benefit. The service member should complete Item 1, Service Member's Name and fill in the his or her Social Security Number at the top of both pages.

The attending physician must complete all sections that are applicable to the service member's injuries. Where a narrative description is required, please be complete and concise. For all sections, except the signature, please type or print legibly.

PART C – To be completed by the Branch of Service (after receipt of completed parts A and B by the Branch of Service)

Section 6 – Traumatic Event Information

Section 6 of the form requests information about the traumatic event that caused the service member's injuries.

If the service member is deceased, please submit a copy of the Report of Casualty (DD-1300) and Form SGLV-8286, indicating the SGLI beneficiaries.

Section 7 - Certification by Branch of Service

Section 7 of the form requests the Branch of Service to certify the service member's SGLI coverage and to verify that the event that caused the service member's injuries qualifies under the regulations that govern this coverage. If the service member had declined SGLI coverage, please submit a copy of the Form SGLV-8286 indicating the declination.

GL.2005.261 Ed. 9/2005 7347-0805-PDF

Page 3 of 9

Certification of Traumatic Injury Protection (TSGLI) Part A—To Be Completed by Service Member

Service member Information First Name
Social Security Number
Branch of Service
Branch of Service
Address of Record (number and street) City State ZIP Code E-mail Address Attorney in Fact Information Important Note: Please include copies of the letters of guardianship, conservatorship, or Power of Attorney, etc. with this form. Failure to include this documentation will Address Apartment (if any) Apartment (if any) Last Name MI Last Name Apartment (if any) City State ZIP Code City State ZIP Code City State ZIP Code Tity Tity
Address of Record (number and street) City State ZIP Code E-mail Address If a guardian or Attorney in Fact Information Important Note: Please include copies of the letters of guardianship, conservatorship, or Power of Attorney, etc. with this form. Failure to include this documentation will Telephone Number National Guard Apartment (if any) Last Name MI Last Name Apartment (if any) City State ZIP Code Lip Code City State ZIP Code Telephone Number Telephone Number
City State ZIP Code E-mail Address If a guardian or an Attorney in Fact will receive payment, please complete the following: Attorney in Fact Information Important Note: Please include copies of the letters of guardianship, conservatorship, or Power of Attorney, etc. with this form. Failure to include this documentation will Telephone Number Telephone Number E-mail Address If a guardian or an Attorney in Fact will receive payment, please complete the following: Mil Last Name Mil Last Name Apartment (if any) City City Telephone Number Telephone Number Telephone Number
E-mail Address E-mail Address If a guardian or Attorney in Fact Information Important Note: Please include copies of the letters of guardianship, conservatorship, or Power of Attorney, etc. with this form. Faiture to include this documentation will Telephone Number E-mail Address If a guardian or an Attorney in Fact will receive payment, please complete the following: First Name MI Last Name Apartment (if any) City State ZIP Code City State Telephone Number Fax Number
E-mail Address E-mail Address If a guardian or Attorney in Fact Information Important Note: Please include copies of the letters of guardianship, conservatorship, or Power of Attorney, etc. with this form. Faiture to include this documentation will Telephone Number E-mail Address If a guardian or an Attorney in Fact will receive payment, please complete the following: First Name MI Last Name Apartment (if any) City State ZIP Code City State Telephone Number Fax Number
Guardian or Attorney in Fact Information Important Note: Please include copies of the letters of guardianship, conservatorship, or Power of Attorney, etc. with this form. Failure to include this documentation will Telephone Number If a guardian or an Attorney in Fact will receive payment, please complete the following: MI Last Name MI Last Name Apartment (if any) City State ZIP Code Telephone Number Telephone Number
Guardian or Attorney in Fact Information Important Note: Please include copies of the letters of guardianship, conservatorship, or Power of Attorney, etc. with this form. Failure to include this documentation will Telephone Number If a guardian or an Attorney in Fact will receive payment, please complete the following: MI Last Name MI Last Name Apartment (if any) City State ZIP Code Telephone Number Telephone Number
Attorney in Fact Information Important Note: Please include copies of the letters of guardianship, conservatorship, or Power of Attorney, etc. with this form. Failure to include this documentation will First Name MI Last Name Apartment (if any) City State ZIP Code Telephone Number Fax Number
Attorney in Fact Information Important Note: Please include copies of the letters of guardianship, conservatorship, or Power of Attorney, etc. with this form. Failure to include this documentation will First Name MI Last Name Apartment (if any) City State ZIP Code Telephone Number Fax Number
Attorney in Fact Information Important Note: Please include copies of the letters of guardianship, conservatorship, or Power of Attorney, etc. with this form. Failure to include this documentation will First Name MI Last Name Apartment (if any) City State ZIP Code Telephone Number Fax Number
Important Note: Please include copies of the letters of guardianship, conservatorship, or Power of Attorney, etc. with this form. Failure to include this documentation will Important Note: Mailing Address (number and street) Apartment (if any) City State ZIP Code Telephone Number Fax Number
Please include copies of the letters of guardianship, conservatorship, or Power of Attorney, etc. with this form. Failure to include this documentation will Mailing Address (number and street) Apartment (if any) City State ZIP Code Telephone Number Fax Number
of guardianship, conservatorship, or Power of Attorney, etc. with this form. Failure to include this documentation will Telephone Number Telephone Number Fax Number
conservatorship, or Power of Attorney, etc. with this form. Failure to include this documentation will Telephone Number City State ZIP Code Lity Telephone Number Fax Number
Power of Attorney, etc. with this form. Failure to include this documentation will Telephone Number Fax Number
Failure to include this documentation will Telephone Number Fax Number
documentation will Telephone Number Fax Number
delay nayment of
the claim.
3 Payment Electronic Funds Transfer (EFT) (Available to service member, guardian, or Attorney in Fact)
Information Bank Name Bank Phone Number
(Please select
only one method of payment)
Bank Routing Number Bank Account Number
Savings Checking
Account Owner's Name
First Name MI Last Name
Note: Prudential's Alliance Account®* (Available to service member only)
Please enter street address only. Mailing Address for Payment Apartment, Ward or Room (if any)
No P.O. Boxes
City State ZIP Code
Payment by Check (Available to guardian, or Attorney in Fact)
4 Signature X
Signature of service member, guardian, or Attorney in Fact Date (MM DD YYYY) Description of Authority

ertification of	Traumatic Injury Protection (TSGLI)	Service member's Social Security Number			
	• •				
Authorization for Release of	Name of Insured:				
for Release of Information to Branch of Service and Office of Servicemembers' Group Life Insurance	First Name MI Last Name				
	Date of Birth (MM DD YYYY) Social Security Number				
	I authorize any health plan, physician, health care professional, hospital, clinic, labor medical examiner or other health care provider that has provided treatment, payme				
TI: (1 : (:	First Name MI Last Name				
	Print Name of Service member				
	or on my (his/her) behalf ("My Providers") to disclose my (his/her) entire medical r and any other health information concerning me (him/her) to the Branch of Service Life Insurance (OSGLI) and its agents, employees, and representatives. Office of Se (OSGLI) is a division of The Prudential Insurance Company of America, headquarter includes information on the diagnosis and treatment of mental illness and the use excludes psychotherapy notes.	and Office of Service members' Group ervicemembers' Group Life Insurance ed in Newark, New Jersey. This also			
	I authorize all non-health organizations, any insurance company, employer, or other information, data or records relating to credit, financial, earnings, travel, activities of				
	Unless limits* are shown below, this form pertains to all of the records listed above	ve.			
	By my signature below, I acknowledge that any agreements I (he/she) have made to restrict my (his/her) protected health information do not apply to this authorization and I instruct My Providers to release and disclose my (his/her) entire medical record without restriction.				
	This information is to be disclosed under this Authorization so that my Branch of Service and OSGLI may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits, 2) obtain reinsurance; 3) administer coverage; and 4) conduct other legally permissible activities that relate to any coverage I (he/she) have (has) or have (has) applied for with OSGLI.				
	This authorization shall remain in force for 24 months following the date of my signature below, while the coverage is in force, except to the extent that state law imposes a shorter duration. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to OSGLI at: 290 West Mount Pleasant Avenue, Livingston, NJ 07039. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that OSGLI has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.				
	I understand that if I refuse to sign this authorization to release my complete medic process my claim for benefits and may not be able to make any benefit payments. I request and receive a copy of this authorization.	•			
	*Limits, if any:				
	Ellino, ir dirj.				
	X Signature of service member, guardian or Attorney in Fact				
	Signature of service member, guardian or Attorney in Fact Date (MM DD YYYY)	Description of Authority			

Certification of Traumatic Injury Protection (TSGLI) Part B—To Be Completed by Attending Physician

1. Patient's Nam	ne		
First Name	N	/II Last Name	
2. Date of Injury (мм	3. What was the injury/diagnos	sis resulting in this claim? (Please print or type)	
If patient is deceased,	1. Date of Death (MM DD YYYY) 2.	. Time of Death	
please provide:		□ : □ □ P. M.	
	3. Cause of Death		
Amputation	If claim is for loss of limbs or digits, plea	se indicate:	
•	Right hand at or above wrist Date of Ampl	utation (MM DD YYYY) Left hand at or above wrist	Date of Amputation (MM DD YYYY)
	Right foot at or above ankle Date of Ampi	outation (MM DD YYYY) Left foot at or above ankle	Date of Amputation (MM DD YYYY)
	Right Thumb Date of Amp	outation (MM DD YYYY) Left Thumb	Date of Amputation (MM DD YYYY)
		utation (MM DD YYYY) Thumb and index finger	Date of Amputation (MM DD YYYY)
	of the right hand	of the left hand	
Loop of Sight	If alaim is far total narmonant lass	If claim is for total permanent loss	If claim is for total permanent loss
Loss of Sight, Speech, or	If claim is for total permanent loss of sight, please give date when this occurred:	of speech, please give date when this occurred:	of hearing, please give date when this occurred:
	of sight, please give date when	of speech, please give date when	of hearing, please give date when
Speech, or	of sight, please give date when this occurred:	of speech, please give date when this occurred:	of hearing, please give date when this occurred:
Speech, or	of sight, please give date when this occurred:	of speech, please give date when this occurred:	of hearing, please give date when this occurred:
Speech, or	of sight, please give date when this occurred: Right Eye (MM DD YYYY)	of speech, please give date when this occurred:	of hearing, please give date when this occurred: Right Ear (MM DD YYYY)
Speech, or	of sight, please give date when this occurred: Right Eye (MM DD YYYY) Left Eye (MM DD YYYY) If claim is for paralysis please complete to	of speech, please give date when this occurred: Date of onset (MM DD YYYY)	of hearing, please give date when this occurred: Right Ear (MM DD YYYY) Left Ear (MM DD YYYY)
Speech, or Hearing	of sight, please give date when this occurred: Right Eye (MM DD YYYY) Left Eye (MM DD YYYY) If claim is for paralysis please complete to Type of Paralysis:	of speech, please give date when this occurred: Date of onset (MM DD YYYY) The following:	of hearing, please give date when this occurred: Right Ear (MM DD YYYY)
Speech, or Hearing	of sight, please give date when this occurred: Right Eye (MM DD YYYY) Left Eye (MM DD YYYY) If claim is for paralysis please complete to	of speech, please give date when this occurred: Date of onset (MM DD YYYY)	of hearing, please give date when this occurred: Right Ear (MM DD YYYY) Left Ear (MM DD YYYY)
Speech, or Hearing Paralysis Brain Injury	of sight, please give date when this occurred: Right Eye (MM DD YYYY) Left Eye (MM DD YYYY) If claim is for paralysis please complete to Type of Paralysis: Hemiplegia Quadriplegia	of speech, please give date when this occurred: Date of onset (MM DD YYYY) The following: Paraplegia following:	of hearing, please give date when this occurred: Right Ear (MM DD YYYY) Left Ear (MM DD YYYY)
Speech, or Hearing Paralysis	of sight, please give date when this occurred: Right Eye (MM DD YYYY) Left Eye (MM DD YYYY) If claim is for paralysis please complete to Type of Paralysis: Hemiplegia Quadriplegia	of speech, please give date when this occurred: Date of onset (MM DD YYYY) The following: Paraplegia following: Duration of Coma:	of hearing, please give date when this occurred: Right Ear (MM DD YYYY) Left Ear (MM DD YYYY) Date of Onset of Paralysis (MM DD YYYY)
Speech, or Hearing Paralysis Brain Injury	of sight, please give date when this occurred: Right Eye (MM DD YYYY) Left Eye (MM DD YYYY) If claim is for paralysis please complete to Type of Paralysis: Hemiplegia Quadriplegia	of speech, please give date when this occurred: Date of onset (MM DD YYYY) The following: Paraplegia following:	of hearing, please give date when this occurred: Right Ear (MM DD YYYY) Left Ear (MM DD YYYY) Date of Onset of Paralysis (MM DD YYYY)
Speech, or Hearing Paralysis Brain Injury	of sight, please give date when this occurred: Right Eye (MM DD YYYY) Left Eye (MM DD YYYY) If claim is for paralysis please complete to Type of Paralysis: Hemiplegia Ouadriplegia If claim is for coma please complete the to Date of Onset of Coma (MM DD YYYY) If claim is for the inability to carry out act	of speech, please give date when this occurred: Date of onset (MM DD YYYY) The following: Paraplegia following: Duration of Coma:	of hearing, please give date when this occurred: Right Ear (MM DD YYYY) Left Ear (MM DD YYYY) Date of Onset of Paralysis (MM DD YYYY) 90 Days
Speech, or Hearing Paralysis Brain Injury	of sight, please give date when this occurred: Right Eye (MM DD YYYY) Left Eye (MM DD YYYY) If claim is for paralysis please complete to Type of Paralysis: Hemiplegia Ouadriplegia If claim is for coma please complete the to Date of Onset of Coma (MM DD YYYY)	of speech, please give date when this occurred: Date of onset (MM DD YYYY) The following: Paraplegia following: Duration of Coma: 15 Days 30 Days 60 Day	of hearing, please give date when this occurred: Right Ear (MM DD YYYY) Left Ear (MM DD YYYY) Date of Onset of Paralysis (MM DD YYYY) 90 Days
Speech, or Hearing Paralysis Brain Injury	of sight, please give date when this occurred: Right Eye (MM DD YYYY) Left Eye (MM DD YYYY) If claim is for paralysis please complete to Type of Paralysis: Hemiplegia Ouadriplegia If claim is for coma please complete the to Date of Onset of Coma (MM DD YYYY) If claim is for the inability to carry out act Date of Onset (MM DD YYYY)	of speech, please give date when this occurred: Date of onset (MM DD YYYY) The following: Paraplegia following: Duration of Coma: 15 Days 30 Days 60 Days stivities of daily living as a result of traumatic brain inju	of hearing, please give date when this occurred: Right Ear (MM DD YYYY) Left Ear (MM DD YYYY) Date of Onset of Paralysis (MM DD YYYY) 90 Days
Speech, or Hearing Paralysis Brain Injury	of sight, please give date when this occurred: Right Eye (MM DD YYYY) Left Eye (MM DD YYYY) If claim is for paralysis please complete to Type of Paralysis: Hemiplegia Uadriplegia If claim is for coma please complete the to Date of Onset of Coma (MM DD YYYY) If claim is for the inability to carry out act Date of Onset (MM DD YYYY) Which of the following functions cannot be in	of speech, please give date when this occurred: Date of onset (MM DD YYYY) The following: Paraplegia following: Duration of Coma: 15 Days 30 Days 60 Day ctivities of daily living as a result of traumatic brain injustice and dependently performed?	of hearing, please give date when this occurred: Right Ear (MM DD YYYY) Left Ear (MM DD YYYY) Date of Onset of Paralysis (MM DD YYYY) 90 Days ary, please complete the following:
Speech, or Hearing Paralysis Brain Injury	of sight, please give date when this occurred: Right Eye (MM DD YYYY) Left Eye (MM DD YYYY) If claim is for paralysis please complete to Type of Paralysis: Hemiplegia Ouadriplegia If claim is for coma please complete the to Date of Onset of Coma (MM DD YYYY) If claim is for the inability to carry out act Date of Onset (MM DD YYYY) Which of the following functions cannot be in Dressing Bathing	of speech, please give date when this occurred: Date of onset (MM DD YYYY) The following: Paraplegia following: Duration of Coma: 15 Days 30 Days detivities of daily living as a result of traumatic brain injustice.	of hearing, please give date when this occurred: Right Ear (MM DD YYYY) Left Ear (MM DD YYYY) Date of Onset of Paralysis (MM DD YYYY) 90 Days Iry, please complete the following:
Speech, or Hearing Paralysis Brain Injury	of sight, please give date when this occurred: Right Eye (MM DD YYYY) Left Eye (MM DD YYYY) If claim is for paralysis please complete to Type of Paralysis: Hemiplegia Uadriplegia If claim is for coma please complete the to Date of Onset of Coma (MM DD YYYY) If claim is for the inability to carry out act Date of Onset (MM DD YYYY) Which of the following functions cannot be in	of speech, please give date when this occurred: Date of onset (MM DD YYYY) The following: Paraplegia following: Duration of Coma: 15 Days 30 Days 60 Day stivities of daily living as a result of traumatic brain injustice in the state of the sta	Of hearing, please give date when this occurred: Right Ear (MM DD YYYY) Left Ear (MM DD YYYY) Date of Onset of Paralysis (MM DD YYYY) 90 Days ary, please complete the following:

Service member's Social Security Number

Certification of Traumatic Injury Protection (TSGLI) Part R.—To Bo Completed by Attending Physician

Part B—To Be	Completed by Attending Physician				
Burns	If claim is for burns, please complete the following:				
	Are there third degree burns to: a. Face? No Yes - Please indicate percentage of face affected by third degree burns %				
	b. Body? No Yes - Please indicate percentage of body affected by third degree burns				
Other Traumatic Injuries	complete the following:				
,	Date of Onset (MM DD YYYY)				
	Which of the following functions cannot be independently performed?				
	Dressing Bathing Toileting Eating Continence Transferring				
	Duration				
	30 Days 60 Days 90 Days 120 Days				
	Comments (if any):				
Physician's Signature	Name of Attending Physician (Please Print) First Name MI Last Name				
Signature	IVI Last value				
	Physician's Address (number and street) Suite				
	Thysician's Address (number and street)				
	City State ZIP Code				
	State Zii Gode				
	Telephone Number Fax Number				
	Tax rumber				
	If civilian physician, please complete: Specialty				
	License Number State of License				
	License Number State of License				
	License Number State of License If military physician, please complete:				

WARNING: Any intentional false statement in this claim or willful misrepresentation relative thereto is subject to punishment by a fine of not more than \$10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001)



Service member's Social Security Number

Certification of Traumatic Injury Protection (TSGLI) Part C—To Be Completed by Branch of Service 6 Traumatic Date of Traumatic Event (MM DD YYYY) Was the service member on duty when the event occurred? **Event** No Yes Information Time of Event-Please use Zulu time (нн мм) Hostile Action? Geographic location where injury occurred Yes No Description of Traumatic Event If service member is deceased, please attach Report of Casualty (DD 1300) and Form SGLV – 8286, indicating SGLI beneficiaries. Date of Death (MM DD YYYY) Cause of Death Certification Was service member covered under SGLI at the time of the traumatic event? by Branch Yes No-Please attach a copy of the form 8286 declining coverage of Service Does the traumatic injury event qualify for Traumatic Injury Protection (TSGLI) under 38CFR9.20? If No, please explain Are you aware of a guardian or Attorney in Fact being appointed for the service member? No 8 Signature Name and rank of person certifying sections 6 and 7 above. (Please Print) First Name MI Last Name Telephone Number Fax Number Rank or Civilian Title Certifying/Contact Office Name Address Line 1 Address Line 2 City State ZIP Code Use reverse side of this form for additional comments. Please print or type clearly. Date (MM DD YYYY) Signature of person certifying sections 6 and 7 above

WARNING: Any intentional false statement in this claim or willful misrepresentation relative thereto is subject to punishment by a fine of not more than \$10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001)



Service member's Social Security Number

CERTIFICATION OF TRAUMATIC INJURY PROTECTION (TSGLI)

Additional comments (if any):				